Madison County School District School Health Program
Permission Form for Prescribed and Over the Counter Medication
(ONLY VALID FOR THE CURRENT SCHOOL YEAR)

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____Student age: _____Date of Birth:_____

Grade:_____Homeroom/Classroom:_____

TO BE COMPLETED BY PARENT / GUARDIAN

************(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)************

Name of medication: _____Reason for medication:_____

ALLERGIES:_____ Any OTHER Condition(s):_____

Form of medication/treatment:_____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school:_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other Instrructions:_____

Parent or Guardian Signature: only valid for the current school year._____Date:_____

Health Care Provider Name_____

Address:_____ Phone:_____ FAX:_____

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date:_____Signature:_____ Relationship:_____

Home phone:_____ Work phone:_____ Emergency or CELL phone:_____

TO BE COMPLETED BY Health Care Provider

♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY♦♦♦

This student is capable, responsible, and demonstrated self-administration of the above medication:

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No** **Any restriction(s):_____**

The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____Date_____

Physician or Authorized Provider: only valid for the current school year.

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.** **MCBE 1 (7-2017)**

Adapted from the Academy of Pediatrics